Town of Scituate Health Reimbursement Arrangement (HRA)
Claim Voucher
JULY 1, 2014 TO JUNE 30, 2015

CPA, INC.
420 Washington Street, Suite 100
Braintree, MA 02184

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(781) 848-8477 (Fax)
(781) 848-9848 (Phone)

EMPLOYEE: _____ **SS#:** __XXX_ - ___XX___ - _____

ADDRESS: _____**CITY:**_____

STATE: _____ **ZIP:** _____**PHONE: ( )**_____**E-MAIL:** _____

HEALTH PLAN (check one): ____**Network Blue HMO** _____**HPHC HMO**

Reimbursement for subscriber and family members enrolled in either Network Blue HMO or HPHC HMO health plans. ALL EXPENSES MUST BE INCURRED BETWEEN JULY 1, 2014 TO JUNE 30, 2015

Type of Medical Care COPAY Expenses	**Reimbursable Amount** **Network BLUE**	**Reimbursable Amount** **HPHC HMO**	**Date(s) of admissions, surgery, or imaging**	**Total Reimbursement** (Number times reimbursable amount)
Example: *Hospital out-patient surgery*	*$150.00 per visit*	*$150.00 per visit*	*7/25/14*	*$150.00*
HOSPITAL ADMISSION	$250.00	$250.00		
HOSPITAL OUT-PATIENT SURGERY	$150.00	$150.00		
HI-TECH IMAGING (MRI, PET SCANS, CT SCANS)	$100.00	$100.00		

TOTAL CLAIM AMOUNT: $_____

This is to certify that I have incurred the expenses listed above that qualify for reimbursement under the Town of Scituate Health Reimbursement Arrangement. I have not been reimbursed from any other source including insurance programs or other programs offered by my employer. None of these expenses have previously been submitted. I understand and agree that since these expenses are to be reimbursed they may not be claimed as deductions for income tax purposes. I hereby request reimbursement for these claims. **All medical claims submitted require copies of original invoices or receipts.**

PARTICIPANT'S SIGNATURE: _____ **DATE**: _____